Review: 4356
Statewide Single Audit
Year Ended June 30, 2010
Department of Healthcare and Family Services

FINDINGS/RECOMMENDATIONS – 24
Repeated – 14

Accepted – 11
Implemented – 12
Under Study – 1

10-13. The auditors recommend DHFS review its current process for performing eligibility redeterminations and consider changes necessary to ensure redeterminations are performed in accordance with federal regulations and the State Plans for each affected program. (Repeated-2007)

Findings: Eligibility redetermination procedures implemented by DHFS for the Children's Health Insurance Program (CHIP) and Medicaid are not adequate.

Effective in February 2006, DHFS revised its procedures for performing eligibility redeterminations for children receiving services under the CHIP and Medicaid programs. The passive redetermination procedures require recipients to review the renewal form and report any changes to eligibility information; however, in the event there are no changes to the information and there are only children on the case, a response is not required.

Upon further review of the passive redetermination process, auditors noted neither DHFS, nor the Illinois Department of Human Services (IDHS) which performs most eligibility determinations for these programs, maintains a formal record of the cases subject to passive redetermination procedures. As a result, auditors were unable to quantify the number of cases subject to the passive redetermination policy.

Payments made on the behalf of beneficiaries of the CHIP and Medicaid programs were $242,508,000 and $8,254,467,000 during FY10.

In discussing these conditions with DHFS officials, they stated the inadequate procedures identified during the audit are the Department's passive redetermination procedures. As to quantifying the number of cases subject to the passive redetermination policy, DHFS stated they are working with DHS to obtain a listing of the cases subject to the passive redetermination procedures.

Updated Response: Partially Implemented. The Department submitted a request to Federal CMS asking that all family health plans require an active renewal annually. Federal CMS has informed Department that eliminating passive renewal would be inconsistent with MOE requirements. Policy changes that would make the renewal

process more restrictive and burdensome and thereby have the effect of restricting eligibility would constitute a violation of the MOE provision of the ACA. They asked the State to develop a plan for incorporating the use of electronic data matching into the annual renewal process and submit it to federal CMS for their approval. The Department is in the process of developing that plan. Once approved, an implementation timeline will be established.

The Department has completed a report to quantify passive redeterminations, which has been run and verified to ensure the data is accurate.

10-14. The auditors recommend DHFS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determination documentation is properly maintained. (Repeated-2009)

Findings: DHFS could not locate case file documentation supporting eligibility determinations for beneficiaries of the Children's Health Insurance Program (CHIP) and the Medicaid programs.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments totaling $168,841 and $200,011, respectively, auditors noted the following exceptions:

- In one CHIP case file (with medical payments sampled of $80), DHFS could not locate adequate documentation supporting income verification procedures were performed. In lieu of collecting copies of pay stubs to verify income, the caseworkers verbally confirmed income information, relied on client handwritten notes, or used income verified on previous applications. Medical payments made were $2,864.

- In ten CHIP case files (with medical payments sampled of $3,297), DHFS could not locate the supporting documentation of the redetermination completed and signed by the beneficiary in the case file. Medical payments made were $62,389 during FY10.

In discussing these conditions with DHFS officials, they stated the cases identified as exceptions were subject to the Department's passive redetermination process.

Updated Response: Under Study. The Department submitted a letter to Federal CMS to request that all family health plans require an annual verification of income. Federal CMS informed the Department that requiring income verification at renewal would be inconsistent with MOE requirements. Policy changes that would make the renewal process more restrictive and burdensome and thereby have the effect of restricting eligibility would constitute a violation of the MOE provision of the ACA. They asked the State to develop a plan for incorporating the use of electronic data matching into the annual renewal process and submit it to federal CMS for their approval. The Department

is in the process of developing that plan. Once approved, an implementation timeline will be established.

10-15. The auditors recommend DHFS review its current process for processing and paying medical payments and consider changes necessary to ensure medical payments are made within the timeframes prescribed within the federal regulations. (Repeated-2008)

Findings: DHFS is not paying practitioner medical claims for individuals receiving benefits under the Children's Health Insurance Program (CHIP) and Medicaid programs within timeframes required by federal regulations.

Federal regulations require the medical providers to submit all medical claims within twelve months of the date of service and require the State to pay 90% of all clean claims within 30 days of the date of receipt and 99% of all clean claims within 90 days of the date of receipt. Further, under the American Reinvestment and Recovery Act (ARRA), states must comply with these claims processing requirements or lose their eligibility for the increased federal medical assistance percentage (FMAP) for certain expenditures. Subsequent to February 17, 2009, any practitioner claim received on a day in which the State was not in compliance with the claims processing requirements is ineligible to receive the increased FMAP rate.

During a review of the analysis covering practitioner medical payments during FY10, auditors noted medical payments were not made within the payment timeframes required. Management's daily analysis of claims processed after the enactment of ARRA identified 24 days in which the State was not in compliance with the claims processing requirements. The State received claims totaling $353,022,405 on those days, resulting in $41,048,595 of lost federal reimbursement.

In addition, during the review of a USDHHS audit and procedures performed, auditors noted the following:

- The agency improperly calculated the prompt payment compliance based on 31 day and 91 day thresholds instead of the required 30 day and 90 day thresholds, and consequently, incorrectly determined some days were eligible for the increased FMAP rate.
- The agency incorrectly excluded categories of claims from its initial prompt payment calculations including zero paid claims with no warrants, denied clean claims, and dental claims previously excluded.
- The agency improperly included certain non-matchable claims in its initial prompt payment calculations.
- The agency did not adjust the financial expenditure report for the quarter ending June 30, 2009 for expenditures not eligible for the increased FMAP rate that were previously claimed on the March 31, 2009 financial expenditure report, and consequently, the agency inappropriately received increased FMAP related to the ineligible expenditures.

As a result of the deficiencies noted above, DHFS was not eligible for $2,586,522 of increased FMAP previously received on $22,262,056 of claims received on days when it did not comply with the prompt payment requirements.

Response: The Department accepts the finding. During the ARRA period, DHFS prioritized Medicaid claims to assure compliance with the regulations to the degree that cash allowed. In the scope of the entire Medical assistance budget, the number of instances where timely payment did not occur was not considered significant. The errors identified in the USDHHS audit had already been corrected by the Department on the Quarter Ending December 2009 CMS 64 quarterly report. The Department will continue to process medical claims within the timeframe required under federal regulations, although they may be held for payment until cash is available.

Updated Response: Implemented. The Department continues to pull practitioner bills well in advance of 30 days (approximately 10 days) and communicates priorities to the Comptroller's cash management staff. As stated in the response, appropriations (funding) and cash availability are the keys to being able to actually pay the bills within the prescribed timeframes.

10-16. The auditors recommend DHFS implement procedures to ensure all hospital assessment payments are disbursed within the required timeframes.

Findings: DHFS did not disburse monthly hospital assessment payments within the required timeframes. The Hospital Assessment Program was approved by the Federal Centers for Medicare and Medicaid Services (CMS) to provide approximately $900 million a year in new federal funding to strengthen Illinois' health care system over five years.

During testwork over monthly hospital assessment payments, auditors noted payments made in July 2009 totaling $77,352,213 that were not paid by the seventh business day of the month. Delays ranged from 18 to 39 days after the required timeframe.

In discussing these conditions with DHFS officials, they stated this was a one-time error that occurred as part of an electronic file submission that resulted in a rejected file. As soon as the rejection was acknowledged, a corrected file was submitted resulting in the late payment. All subsequent months were processed in a timely manner, resulting in no financial impact to either DHFS or the providers.

Updated Response: Implemented. The Department has assigned additional personnel to review the file to assure that the annual changeover of fiscal year notes reflect the change in year.

10-17. The auditors recommend DHFS implement procedures to ensure provider audits are performed and completed in a timely manner. (Repeated-2008)

Findings: DHFS did not initiate and complete audits of providers of the Children's Health Insurance Program (CHIP) and Medicaid programs in a timely manner.

During testwork over 50 providers recommended by the OIG for audit, auditors noted there were significant time delays between the date DHFS determined a provider audit should be performed and the start date of the audit. Specifically, nine of the 50 provider audits tested had not been started as of the date of testwork. The number of days that had elapsed ranged from 191 to 798 days. For the 41 provider audits completed, the number of days that had elapsed between the dates the provider was recommended for audit and the audit start date ranged from six to 1,121 days. In addition, provider audits were not completed in a timely manner.

In discussing these conditions with DHFS officials, they stated that one audit was not completed timely due to staff turnover. The second audit was not completed timely because a customized audit protocol was utilized, which required significant manual data entry to determine discrepancies. The last audit noted as untimely was delayed due to availability of information to be audited.

Response: The Department accepts the finding. It should be noted that there is no federally prescribed timeframe for completion of provider audits; however, the OIG strives to complete all audits in a timely manner. As with the nature of the audit profession, situations occur that may extend the time necessary to complete the audit such as the type and volume of documentation to be audited (hospital records vs. individual practitioner records) the type of audit (i.e. pharmacy script audit vs. pharmacy inventory audit) or the availability of the information to be audited. There are also delays due to external entities such as the Federal Bureau of Investigation or Illinois State Police performing investigations on the same auditee. As agreed to in the exit interview with KPMG, these types of extenuating circumstances must be and will be considered during the assessment of an audit being completed timely.

The timeframes listed above are indicative of OIG's efforts to reduce the length of time to complete any audit. The OIG will further enhance the controls in place to improve the process for completing audits within 180 days. The OIG will also ensure adequate documentation is maintained to support any extenuating circumstances that cause audits to surpass the 180 day timeframe.

Updated Response: Accepted. The Bureau Chief, Assistant Bureau Chief and Audit Manager for the OIG Bureau of Medicaid Integrity meet on a monthly basis to review all open audit cases. In addition, the OIG has completed the assessment of the workflow and have determined the necessary changes to maintain efficient and expeditious throughput for audit tasks. The OIG Bureau of Information Technology is currently working on the system changes need to implement the new workflow.

10-18. The auditors recommend DHFS review its current process for performing Medicaid Eligibility Quality Control (MEQC) reviews and consider changes

necessary to ensure reviews are completed in a timely manner and summary reports are submitted within the timeframes required by CMS. (Repeated-2008)

Findings: DHFS did not complete Medicaid Eligibility Quality Control (MEQC) reviews in a timely manner.

The DHFS Office of the Inspector General (OIG) is responsible for performing and reporting the results of quality control reviews of beneficiary eligibility determinations performed by the State for the Medicaid and CHIP programs. In place of the traditional MEQC program, the OIG participates in various MEQC pilot programs which target specific eligibility risk areas. These reviews are designed to assist the State in monitoring the accuracy of eligibility determinations and the appropriateness of medical payments made on the behalf of beneficiaries. The results of these reviews are required to be reported to the Center for Medicare and Medicaid Services (CMS) within ten months of the end of the applicable fiscal year.

During the review of the 1,177 pilot program reviews completed in FY10, auditors noted reviews were not completed within a reasonable timeframe as follows:

Timeframe	Number of Reviews
0-60 days	490
61-120 days	512
121-180 days	155
181-240 days	17
240 + days	3

In discussing these conditions with DHFS officials, they stated the reviews were not completed timely due to staff turnovers and delayed receipt of information from 3rd party resources.

Response: The Department accepts the finding. It should be noted that the only federally prescribed timeframe for completing MEQC reviews is the submission of the summary of findings by August 1 for the previous year's review; however, the OIG strives to complete MEQC reviews in a timely manner. There are circcumstances, such as the delay in receiving information back from a critical 3rd party resource, that may extend the time to complete a review.

The OIG is implementing controls to improve the process for ensuring the MEQC reviews are completed within 180 days. These controls include improving monitoring reports and higher level management approvals for exceptions to completion target dates.

Updated Response: Implemented. OIG management is using an Aging Report to monitor the timeliness of the reviews. Specifically, the Aging Report is reviewed by the supervisory and managerial staff and then discussed with the Bureau Chief and Assistant Bureau Chief in monthly conferences.

10-19. The auditors recommend DHFS review its current process for monitoring and reporting overpayments and implement any changes necessary to ensure such overpayments are reported on the quarterly financial expenditure reports and returned to the federal government.

Findings: DHFS does not have an adequate process to monitor and report overpayments identified with providers of the Home and Community Based Services Waiver programs administered by the Illinois Department of Human Services (IDHS).

Specifically, DHFS did not report Medicaid overpayments identified by the Fraud Unit for services provided from December 1, 1999 through December 31, 2008 on quarterly financial expenditure reports in accordance with federal requirements. 75 overpayments (totaling $26,383) out of 100 overpayments tested (totaling $134,449) were not reported on quarterly financial expenditure reports and, consequently, were not returned to the federal government. Overpayments identified by the Fraud Unit from December 1, 1999 through June 30, 2009 totaled $3,874,265.

Auditors noted DHFS has not modified its process for reporting these overpayments since receiving the federal audit report. Overpayments identified by the federal audit were $940,704 for the year ended June 30, 2010.

In discussing these conditions with DHFS officials, they stated that they did not report the overpayments as they had not developed and implemented internal controls to ensure overpayments identified by the Fraud Unit were reported on the CMS-64.

Response: The Department accepts the finding. The Department has refunded the amount identified. The Department will work with DHS to assure that it is aware of the requirement to inform us when Medicaid overpayments are identified. Furthermore, the Department will perform routine follow up to verify that DHS complies with this requirement.

Updated Response: Accepted. The Department has scheduled meetings with DHS/DRS to discuss progress on developing and implementing necessary system changes. Upon completion the department will perform routine follow up to verify that DHS complies with this requirement.

10-20. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received.

Findings: DHFS does not have adequate procedures in place to verify with beneficiaries of the Medicaid Cluster program whether services billed by providers were actually received.

During testwork, auditors noted DHFS procedures for verifying with beneficiaries whether services billed by providers were actually received by Medicaid Beneficiaries consisted of

special projects performed by the DHFS Office of Inspector General and Bureau of Comprehensive Health Services. However, the current projects only cover procedures billed by non-emergency transportation providers, optometric providers, and dental providers which only account for 2% of total provider reimbursements. Further, DHFS does not perform any verification procedures for services billed by the following provider types:

- Hospitals
- Mental Health Facilities
- Nursing Facilities
- Intermediate Care Facilities
- Physicians
- Other Practitioners
- Managed Care Organizations
- Home and Community-Based Service Providers
- Physical Therapy Providers
- Occupational Therapy Providers

In discussing these conditions with DHFS officials, they stated that processes utilized by DHFS, IDHS and IDPH appeared to meet the federal requirement, which was supported by no exceptions noted during the recently completed federal Program Integrity audit.

Response: The Department accepts the finding. There are various recipient verification processes employed by DHFS, in conjunction with DHS and IDPH. DHFS also incorporated the requirement for the Medicaid Managed Care Organizations (MCOs) to perform recipient verification in the current MCO contracts and the MCOs began conducting these verifications during FY10. The Department will develop a risk-based methodology to perform recipient verification for the remaining high risk provider types that are not covered by other processes.

Updated Response: Accepted. The design phase for the development of a risk-based methodology to perform recipient verifications is scheduled to begin January 1, 2012. The scheduled implementation date is March 1, 2012.

10-21. The auditors recommend DHFS review its current process for calculating provider reimbursements and consider the changes necessary to ensure provider payments are properly calculated and paid. (Repeated-2009)

Findings: DHFS did not properly reimburse a provider of the Medicaid program in accordance with its established reimbursement methodology.

During testwork of Medicaid Cluster program beneficiary payments, auditors selected a sample of 125 beneficiary payments (totaling $200,011) to review for compliance with eligibility requirements and for the allowability of the related benefits. For one provider reimbursement, auditors noted that DHFS erroneously calculated a reimbursement using

a provider rate of $1,151 for a claim where actual charges totaled $957. Upon review of all charges included in the retroactive rate adjustment calculation, DHFS identified the provider received overpayments of $20,021 relative to 33 claims in which actual charges were less than the negotiated rate.

In discussing these conditions with DHFS officials, they stated claims were adjusted due to being incorrectly priced as Per Diem, instead of DRG.

Response: The Department accepts the finding. The 33 claims, including this particular claim, were determined as affected, and have been correctly adjusted. Repricing logic will include an additional step to ensure future adjustments do not exceed the provider's billed charges.

Updated Response: Implemented. The DRG exclusion code error was a data entry error, however, an additional step has been added to the repricing logic limiting payment to the lesser of computed payment or covered charges.

10-22. The auditors recommend DHFS review its current process identifying and recouping ineligible reimbursements and consider any changes necessary to ensure provider recoupments are identified and made in a timely manner.

Findings: DHFS did not identify and recoup an ineligible reimbursement for a beneficiary of the Medicaid Managed Care program.

In the review of a Managed Care provider reimbursement for one Medicaid beneficiary for $1,780 selected for testwork, auditors noted a recipient continued to receive benefits under the Managed Care program despite moving to an address outside the service area of the specific health plan participating in the Managed Care program. Despite notifying the Illinois Department of Human Service (IDHS) of the move on December 2, 2009, eligibility for the health plan for the recipient was not terminated until the physical case file was transferred to the IDHS local office responsible for maintaining the case file under the new service area on January 31, 2010. Ineligible Managed Care program reimbursements for this beneficiary that occurred from December 2, 2009 through January 31, 2010 totaled $3,910.

In discussing these conditions with DHFS officials, they stated that when the enrollee moved out of the Managed Care Organization (MCO) contracting area, DHS did not take action to transfer the case in a timely manner, thereby not closing out the MCO. The MCO continued to receive the capitation payment until DHS took action to update the case to show the client had moved. At that point, DHFS completed a disenrollment form and initiated recoupment of the capitation payment back to the beginning of the month the client moved out of the contracting area.

Response: The Department accepts the finding. The Department will notify DHS that action to transfer cases needs to be completed in a timely manner. The Department will continue to ensure provider recoupments are processed as required.

Updated Response: Implemented. The Department retroactively disenrolled the client from the MCO and voided the capitation payment to the MCO in February, 2011. The Department of Human Services (DHS) developed a new procedure and policies allowing the HFS hotline to update client addresses in the DHS and HFS eligibility systems.

10-23. The auditors recommend DHFS implement procedures to ensure all disproportionate share hospital payments are updated and made in a timely manner to government owned hospitals.

Findings: DHFS did not update and make disproportionate share hospital payments in a timely manner to government owned hospitals participating in the Medicaid Cluster.

On December 4, 2008, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to the Medicaid State Plan, which changed the methodology for reimbursing two government owned hospitals participating in Medicaid and was retro-active as of July 1, 2008. Each hospital was to receive an annual disproportionate share hospital award which is required to be paid out in twelve equal monthly installments throughout the year.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors reviewed provider reimbursements for accuracy and the allowability of the related benefits provided. During those procedures, the following exceptions related the provider reimbursements and disproportionate share hospital payments:

- For one of the government owned hospitals, an updated interagency agreement reflecting the changes made by the Medicaid State Plan amendment to the methodology for calculating reimbursement rates was not executed until March 9, 2010, 460 days after the State Plan was amended and 616 days after the methodology was implemented. The methodology used to reimburse the hospital was not updated to agree with the changes made by the Medicaid State Plan amendment until July 7, 2009, 217 days after the State Plan was amended.
- The agency did not set the per diem rates for the two providers until September 20, 2010 and June 29, 2010, respectively.
- Because the agency did not set the provider per diem rates for 2009 until July 7, 2009 and May 20, 2009, these hospitals' previous reimbursements were subsequently adjusted by $31,602,000 and $10,359,157, respectively, during the year ended June 30, 2010.
- For one provider, the disproportionate share hospital payments of $123,006,230 for the period October 2007 through September 2008 were not made until November 9, 2009.

- For the second provider, the disproportionate share hospital payments of $29,187,500 for the period July 2008 through July 2009 were not made until September 11, 2009.

Total medical reimbursements and disproportionate share hospital payments made to these two providers of the Medicaid Cluster and CHIP program totaled $847,519,000 and $479,711,000, respectively, during FY10. Payments made on behalf of beneficiaries of the CHIP and Medicaid Cluster programs totaled $242,508,000, and $8,254,467,000, respectively.

In discussing these conditions with DHFS officials, they stated this was an isolated incident that occurred as a result of transitioning the rate methodology for two government providers.

Response: The Department accepts the finding. The Department has streamlined the process which was agreed to between the Department and the providers, resulting in a timelier implementation of rates. A limited amount of lag is expected to be an option, as the initial rates are considered interim until final data is received, reviewed and agreed to between the State and the Local Government providers.

Updated Response: Accepted. The Department is finalizing new procedures manual, outlining annual rate determination schedule and step, including rate calculation redundancy protocols. The Department will publish rate sheets to providers as soon as provider supplied cost report information is deemed finalized. The Department will also begin the process to finalize the requisite cost report information used in the rate determination earlier each calendar year. These items are expected to be completed effective January 1, 2012.

10-24. The auditors recommend DHFS update the provider agreements for the 734 providers enrolled between June 2007 and December 2009 and obtain the required information about ownership and control, business transactions, and criminal convictions. (Repeated-2009)

Findings: During testwork of the CHIP and Medicaid programs, auditors noted the DHFS standard provider applications and agreements used from June 2007 through December 2009 (during which 734 new providers were enrolled) did not address all elements of the required disclosures about ownership and control, business transactions, and criminal convictions. Further, no procedures have been performed to obtain the missing information from these 734 providers as of the date of this report.

In discussing these conditions with DHFS officials, they stated that there has always been a requirement on the Provider Enrollment Application that providers comply with federal regulations. The Department used the federal disclosure statement (CMS-1513) to gather the required ownership disclosure until discontinuance of the form in June of 2003. In

June 2006, CMS redesigned the CMS-1513, which the Department instituted in June of 2009 for all newly enrolled providers.

Updated Response: Accepted. The Department reviewed and noted that there were only 653 active providers of the 734 providers identified in the finding, of which 248 already had 1513's in their file. The Department sent letters to the remaining 405 providers to obtain the required statement. The Department has obtained the requisite 1513 for 324 providers from the remaining providers. The Department will follow up with phone calls to the remaining 81 providers in November and December to obtain the required statement. The Department is requiring disclosure statement on all new providers.

10-25. The auditors recommend DHFS review its on-site monitoring procedures for subrecipients of its Child Support program and implement changes necessary to ensure procedures performed adequately address all compliance requirements that are direct and material to subrecipients. (Repeated-2008)

Findings: DHFS did not perform adequate on-site monitoring procedures for subrecipients of the Child Support Enforcement program.

DHFS passes through Child Support program funding to various local governments within the State to administer particular aspects of operating the program, including locating absent parents, assisting in establishing paternity, obtaining child support obligations, and enforcing support obligations owed by non-custodial parents.

During the review of the on-site monitoring procedures performed by DHFS for a sample of 16 subrecipients, auditors noted DHFS has not developed adequate procedures to monitor all relevant fiscal and administrative processes and controls of its subrecipients. Specifically, on-site monitoring procedures are not performed to determine whether subrecipients are documenting administrative expenditures in accordance with the applicable cost principles or whether subrecipients are following appropriate procurement procedures.

Updated Response: Implemented. The Department has completed a draft Monitoring Procedures and Review Tool. The draft is being circulated among the Department's Senior Staff for review and comment. Completion of the first review is estimated to be done by December 1, 2011.

10-26. The auditors recommend DHFS establish procedures to ensure management decisions are issued for all findings affecting its federal programs in accordance with OMB Circular A-133. (Repeated-2008)

Findings: DHFS did not issue management decisions on OMB Circular A-133 findings for subrecipients of its Child Support Enforcement program and Medicaid program. During testwork over OMB Circular A-133 audit reports for sixteen subrecipients of the Child Support program, auditors noted the following:

- The audit report for one subrecipient reported three separate instances of noncompliance. DHFS did not issue a management decision relative to these findings or follow up on the conditions identified in the findings. Amounts passed through to this subrecipient were $55,459.
- The audit report for one subrecipient reported three separate instances of noncompliance. Although DHFS performed procedures to follow up on this finding with the subrecipient, DHFS did not issue a management decision relative to these findings. Amounts passed through to this subrecipient were $24,416.
- The audit report for one subrecipient reported the subrecipient did not have a general ledger system that specifically identified individual federal receipts and disbursements for each federal program. Although DHFS performed procedures to follow up on this finding with the subrecipient, DHFS did not issue a management decision relative to this finding. Amounts passed through to this subrecipient were $211,619.
- The audit report for one subrecipient reported two separate instances of noncompliance. Although DHFS performed procedures to follow up on this finding with the subrecipient, DHFS did not issue a management decision relative to these findings. Amounts passed through to this subrecipient were $682,660. Auditors also noted that this subrecipient received Medicaid funding of $1,200,005.
- The audit reports of two subrecipients were not reviewed within the required six months after receiving the reports. Delays in completing the desk reviews were 175 and 212 days after the required timeframe.

In discussing these conditions with DHFS officials, they believed adequate procedures were performed when conducting the reviews. The A-133 checklist was utilized as a guide during the review of the findings affecting federal programs related to DHFS, and discussions were held with the applicable program areas regarding the findings prior to issuing a management decision letter to the subrecipient.

Updated Response: Implemented. The Department has updated the procedural manual, including adding management letter examples, to ensure follow up is performed on the conditions identified in the findings; ensure findings affecting HFS programs are clearly referenced in the management decision letter; and clearly referencing the outcome of the entity's corrective action in the management decision letter.

10-27. The auditors recommend DHFS review its procedures for ensuring the need to have an audit in accordance with OMB Circular A-133 and consider any changes necessary to ensure this requirement is properly included in grant agreements for subrecipients of the Child Support program.

Findings: DHFS did not communicate the requirement to have an audit in accordance with OMB Circular A-133 in grant agreements for subrecipients of the Child Support Enforcement program. During the review of subrecipient award notifications for a sample of 16 subrecipients, auditors noted DHFS did not communicate to two subrecipients the need for an audit in accordance with OMB Circular A-133.

In discussing these conditions with DHFS officials, they stated the grant award documents should have included the OMB Circular A-133 language.

Updated Response: Implemented. The Department added the language referencing the A-133 audit requirement to all Subrecipient agreements/contracts.

10-28. The auditors recommend DHFS develop comprehensive written procedures for determining which subrecipients should be selected for on-site reviews. (Repeated-2008)

Findings: DHFS is not adequately performing on-site monitoring for subrecipients of the Medicaid program.

DHFS passed through approximately $11,889,778 in Medicaid funding to the County Health Departments (CHDs) during FY10 to assist DHFS in identifying students whose families may need Medicaid assistance and to monitor the coordination of the student's medical care.

During the review of the monitoring procedures performed by DHFS, auditors noted DHFS has not established measurable selection criteria for determining which subrecipients will be subject to on-site monitoring procedures on an annual basis. Although DHFS has established a risk based approach to selecting subrecipients for desk reviews of administrative claims, DHFS was unable to adequately demonstrate the correlation between subrecipients identified as high risk for desk reviews and those selected for on-site reviews.

In discussing these conditions with DHFS officials, they stated that budget constraints required the Department to limit on-site reviews to larger subrecipient groups, such as Local Education Agencies.

Updated Response: Accepted. The Department has corresponded with Department of Human Services in regard to exchanging documentation of their on-site review. DHS will compile and provide the on-site review documentation to HFS for additional review.

10-29. The auditors recommend DHFS implement procedures to ensure quarterly expenditure reconciliations are performed and completed in a timely manner and adjustments identified in the reconciliation process are made in a timely manner. (Repeated-2009)

Findings: DHFS did not complete quarterly cash management reconciliations of cash draws to actual expenditures for assistance payments made under the Medicaid, CHIP, and Child Support Enforcement (CSE) programs or make adjustments identified as a result of these reconciliations in a timely manner (quarterly). Auditors noted the following differences in the review of the quarterly reconciliations of the CSE, CHIP, and Medicaid Cluster programs:

	Medicaid		CHIP		CSE
Quarter	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed	Date Reconciliation Completed
09/30/09	$98,743,182	6/14/10	($32,908,425)	1/29/10	3/25/10
12/31/09	($62,109,109)	6/16/10	($15,528,339)	4/29/10	6/24/10
03/31/10	($118,704,577)	6/16/10	($2,535,098)	6/18/10	11/29/10
06/30/10	($133,118,764)	8/30/10	($22,518,322)	8/27/10	11/29/10

In discussing these conditions with DHFS officials, they stated that the quarterly reconciliations were not completed as timely as usual due to on-going discussions with federal CMS central office staff regarding the proper handling (claiming, offsets, negative grant awards and reconciliation) of Medicare A and B premiums. This required research by the Department and on-going discussions with federal CMS central office staff. Due to concerns regarding the appropriate handling of these transactions, the reconciliations and adjustments were not completed as timely as usual.

Response: The Department accepts the finding. A full-time staff person has been assigned to complete the reconciliations each quarter. The Department will also utilize additional staff in the preparation and review of the quarterly reconciliations to increase timeliness as needed.

Updated Response: Implemented. The Department completed all quarterly cash reconciliations through QE 3/31/2011 by May 31, 2011. The Department will complete adjustments to future cash draws required pursuant to the reconciliations.

10-30. The auditors recommend DHFS implement procedures to ensure cash draws are performed in accordance with the Treasury-State Agreement. (Repeated-2008)

Findings: DHFS does not have adequate procedures in place to ensure Medicaid program cash draws are performed in accordance with the Treasury-State Agreement (TSA).

Annually, the State of Illinois negotiates the Treasury-State Agreement with the US Department of the Treasury which details the funding techniques to be used for the draw down of federal funds. DHFS is required to request funds based on actual cash outlays for direct administrative costs during the month. Because the funding technique is on a reimbursement basis, it is interest neutral.

During follow-up on prior year findings relating to subrecipients of the Medicaid program, auditors noted the State's cash draws for payments to Local Education Agencies (LEAs) were performed on an advance basis (prior to paying the LEAs). Upon review of all cash draws for payments to LEAs during FY10, the number of days cash was drawn in advance of actual cash outlays ranged from one to 14 days.

In discussing these conditions with DHFS officials, they stated they believed that the funding technique included in the TSA for payments to LEAs was appropriately being utilized.

Updated Response: Partially Implemented. The amendment to the Treasury State Agreement was submitted to GOMB on 10/21/2011. Interest calculation on LEA pass through draws will be performed in December 2011, as part of the CMIA Annual Report for State Fiscal Year 2011.

10-31. The auditors recommend DHFS develop procedures to ensure indirect costs are coded to the correct cost centers and claimed at the proper reimbursement rate. (Repeated-2008)

Findings: DHFS did not accurately allocate costs to its federal programs in accordance with the Public Assistance Cost Allocation Plan (PACAP).

During the review of costs allocated to federal programs during the quarter ended December 31, 2009, auditors noted DHFS allocated overhead costs to the "Special Assistance for Health Insurance Portability and Accountability and Computers Security Programs" cost center rather than directly charging these costs to the Medicaid Infrastructure Grant in accordance with PACAP. As a result, DHFS under reported Medicaid claimable expenditures for indirect costs by $904.

In discussing these conditions with DHFS officials, they stated that the condition occurred as the result of a data entry error.

Updated Response: Implemented. The Department entered a prior period adjustment on the CMS 64 and CMS 21 for QE 9/30/10 to correct the overage to Medicaid indirect costs on 10/29/10. The Department will continue supervisory review of claim work papers.

10-32. The auditors recommend DHFS establish procedures to ensure that vendors contracting with DHFS are not suspended or debarred or otherwise

excluded from participation in federal assistance programs. (Repeated-2009)

Findings: DHFS did not obtain required certifications that vendors were not suspended or debarred from participation in federal assistance programs for the Child Support Enforcement, Children's Health Insurance Program, and Medicaid Programs.

During a review of twenty vendors of the Child Support Enforcement program and 20 vendors allocated to all federal programs, auditors noted DHFS did not include a suspension and debarment certification in 16 of its vendor agreements. Additionally, DHFS did not perform a verification check with the "Excluded Parties List System" (EPLS) maintained by the General Services Administration for vendors.

In discussing these conditions with DHFS officials, they stated 15 of the 16 contracts identified are master contracts entered into between the vendor and the Illinois Department of Central Management Services (CMS). The remaining contract was executed prior to the CMS boilerplate being updated by CMS to include the required disclosures and certifications for suspension and debarment.

Updated Response: Accepted. The Department is in the process of researching, developing and issuing updated procurement policy to require staff to secure the required disclosures for all contracts. After completion of this process, the Department will train staff on the updated procurement policy.

10-33. The auditors recommend DHFS implement procedures to ensure that all procurements are performed in accordance with the applicable rules and regulations.

Findings: DHFS did not competitively bid a professional service contract for $31,200 purchased for the administration of the Child Support program.

In discussing these conditions with DHFS officials, they stated that the procurement did not qualify as a Professional & Artistic contract per DHFS Office of General Counsel (OGC) and the Office of State Procurement Officer (OSPO) and, therefore, was not bid out.

Updated Response: Implemented. The Department will continue to review all contracts to ensure they are bid out when required, however, they consider this an isolated incident.

10-34. The auditors recommend DHFS follow procedures established to ensure support orders are established within the required timeframes and ensure failed attempts to establish support orders are adequately documented.

Findings: During testwork of 40 child support cases, in one case DHFS did not make timely attempts to enforce and obtain medical insurance of the absent parent. Auditors noted that attempts were made to serve the court order in October 2006 with no subsequent attempts made to add the insurance. The insurance was subsequently added in November 2010 after testwork.

In discussing these conditions with DHFS officials, they stated they believe that the case has documented Medical Support Obligation. As the KIDS system did not have an updated address for Aetna at the time of receiving notification of insurance, the worker was unable to enter the data. Therefore, the worker entered the data on the Notes screen to show compliance. According to Department records, the insurance was placed and enforced on the system, and verified with Aetna.

Response: Accepted. The Department considers this a one time incident, however, they will continue to obtain and enforce medical insurance of the absent parent as required.

10-35. The auditors recommend DHFS implement procedures to ensure that approved cost allocations included in the Public Assistance Cost Allocation Plan (PACAP) are followed.

Findings: DHFS did not follow the approved allocation methodology in the Public Assistance Cost Allocation Plan (PACAP) to allocate certain cost centers to the Children's Health Insurance Program (CHIP) and Medicaid Cluster programs.

DHFS administers federal and State programs to provide healthcare coverage for Illinois adults and children. In administering these programs, DHFS incurs significant expenditures, which are directly and indirectly attributable to the administration of its programs.

During the review of costs allocated to federal programs during the quarter ended December 31, 2009, auditors noted the PACAP prescribed that expenditures from a specific cost center be allocated to the "Bureau of All Kids". However, based on payroll records and time certifications, expenditures totaling $146,490 from the cost center were allocated using the "Supportive Medical" allocation methodology. As a result, costs of $146,490 were allocated to Medicaid instead of CHIP and State funded programs.

In discussing these conditions with DHFS officials, the Department agreed that the costs were not being allocated to the cost pool indicated on the December 2009 PACAP. This is due to the fact that the PACAP did not accurately reflect the correct cost pool for these costs. Based upon the duties being performed, the costs were being allocated to the correct cost pool. The US DHHS Department Appeals Board rulings have stated that costs must be allocated consistent with actual duties performed regardless of the methodologies in the PACAP. The expenditures were allocated appropriately.

Updated Response: Implemented. The Department submitted the PACAP amendment with an effective date of January 1, 2011 clarifying the language seeking a revision to the designated cost pool. The amendment was approved by the U.S. DHHS Division of Cost Allocation on 6/21/2011.

10-36. The auditors recommend DHFS implement procedures to ensure all financial reports are submitted within the established deadlines.

Findings: DHFS does not have a process in place to ensure financial reports are prepared and submitted within required timeframes.

DHFS is required to prepare various quarterly financial reports relative to awards under the Child Support Enforcement, CHIP, and Medicaid programs. During testwork over the financial reports required to be submitted during FY10, auditors noted the following:

- Six quarterly reports (out of eight tested) for the Child Support Enforcement program were not submitted by the reporting deadline. Delays ranged from three to 24 days.
- One quarterly report (out of four tested) for the CHIP program was not submitted by the reporting deadline. The delay was 31 days.
- One quarterly report (out of four tested) for the Medicaid Cluster was not submitted by the reporting deadline. The delay was 31 days.

In discussing these conditions with DHFS officials, they stated that there were several reasons for the lateness of the reports, including: an error that occurred during programming changes; needing additional time to accurately prepare and certify the claims; requests received from federal staff to make an adjustment to costs claimed; time required to research and calculate the appropriate adjustment amount; receipt of federal guidance regarding the proper reporting of estimated administrative expenditures; and time required to determine the effect of the guidance on the budget estimate.

Updated Response: Implemented. The Department will continue to file claims according to the due dates outlined in bureau reference manual/procedures. All claims and reports for SFY11 were filed timely.